The Color Line In Health

The Southern PATRIOT

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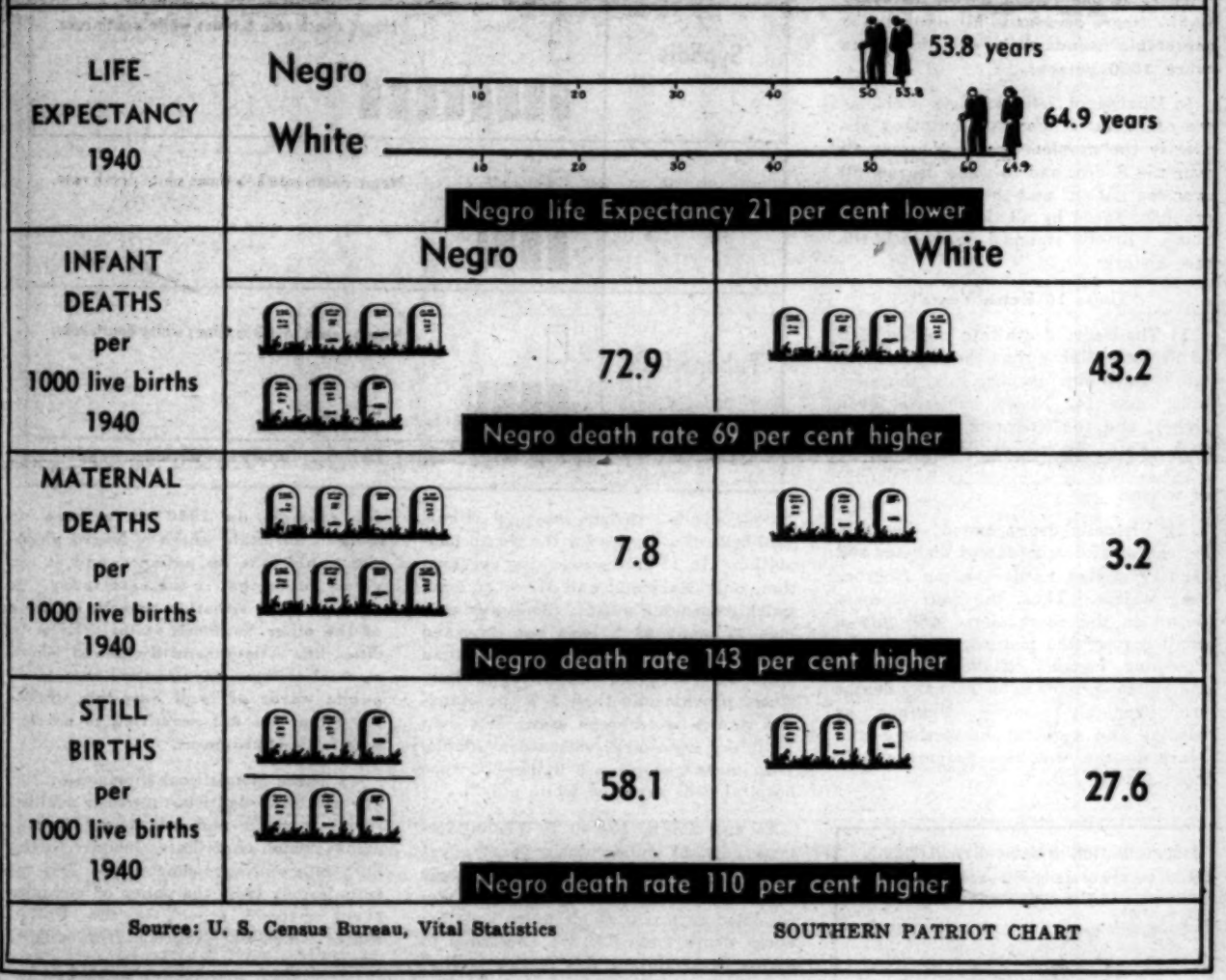
THE COST OF SEGREGATION IN LIVES



Source: U. S. Census Bureau, Vital Statistics — SOUTHERN PATRIOT CHART

Behind the cold figures in this chart lie hundreds of thousands of human tragedies.

The human victims, certain primitive peoples sacrified to their gods, were few indeed compared with the number our Christian democratic society sacrifices to maintain the color line.

Segregation has meant that medical care is cruelly inadequate in our whole Negro population—virtually nonexistent for many. Inadequate medical care means that men, women and children die, who, with proper care, should have lived.

Segregation has meant a higher death rate for Southern whites as well. Germs know no color line.

The inferior health of the South as a whole was dramatically demonstrated during the war, when half of our Southern draftees were rejected as unfit for service. The following pages show that segregation is one of the prime causes of this regional health differential and a major challenge to our ability to develop an effective democracy.

CASE HISTORY

Let's begin with Mississippi.

3,722 Mississippi citizens died without medical care in 1937. 531 of them had white skins; 3,191 had black.

Of every 100 Negro children born in Mississippi, only 17 are given their first spank by a doctor; 83 are delivered by midwives or without any assistance.

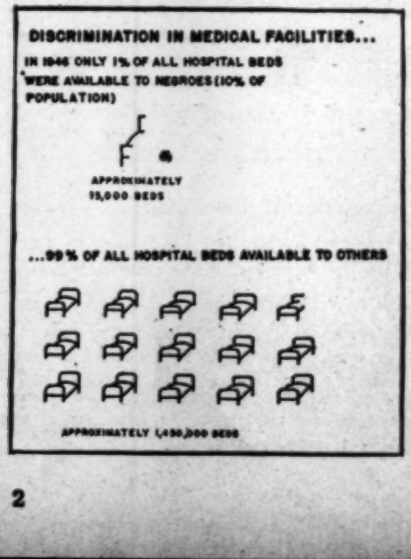
There is one Negro doctor to every 18,527 Negro persons in Mississippi; the acceptable standard is one doctor to every 1500 persons.

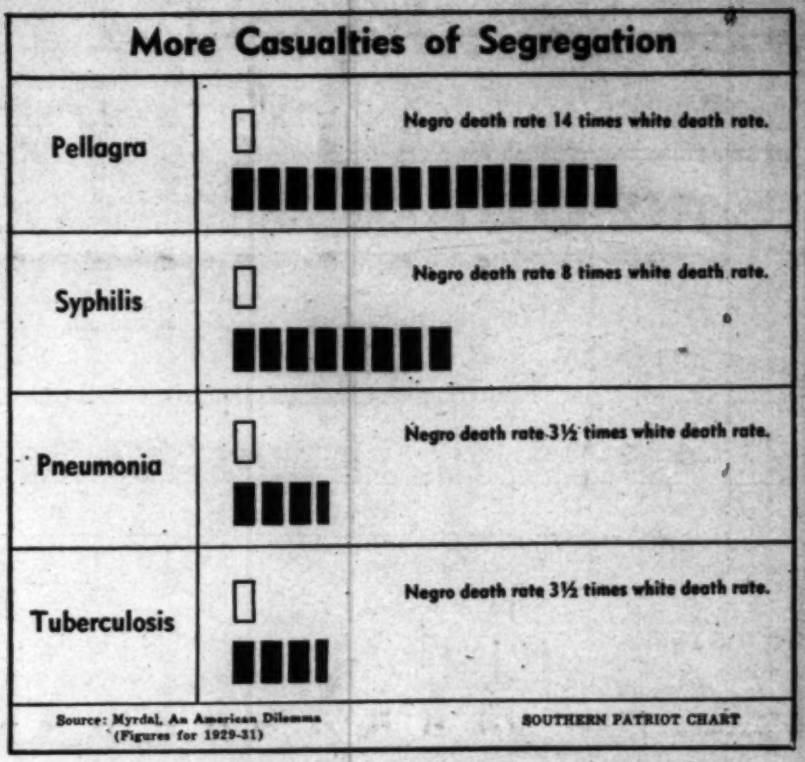
In Mississippi, some of these problems are exaggerated, perhaps, but they are exactly the problem facing Negroes all over the South, and to some degree, all over the nation: and they are the same problems faced by all the people in the South. Briefly summed up, here is the case history:

"Those 10 Extra Years"

1) The Negro death rate is more than 33 per cent higher than the white death rate. As shown on page one, the mortality rate for Negro babies is even higher, and for Negro mothers, higher still. Thus the life expectancy of Negroes is 10 to 12 years shorter than that of whites.

2) Virtually every one of the leading causes of death (except diabetes and cancer) strikes harder among Negroes than whites. Thus, the four diseases shown in the chart above are only a small part of the picture; for example, whooping cough, influenza, nephritis and enteritis cause twice as many deaths proportionately among Negroes as whites; and cerebral hemorrhage and heart disease, are also proportionately more deadly.


DISCRIMINATION IN MEDICAL FACILITIES...
IN 1946 ONLY 1% OF ALL HOSPITAL BEDS WERE AVAILABLE TO NEGROES (10% OF POPULATION)
APPROXIMATELY 13,000 BEDS
...99% OF ALL HOSPITAL BEDS AVAILABLE TO OTHERS
APPROXIMATELY 1,430,000 BEDS

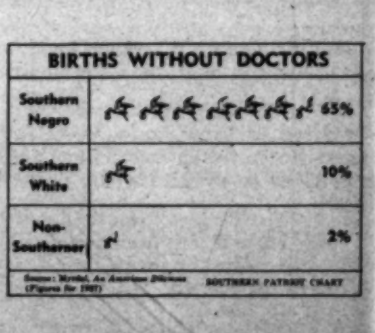

More Casualties of Segregation
Pellagra
Negro death rate 14 times white death rate.
Syphilis
Negro death rate 8 times white death rate.
Pneumonia
Negro death rate 3½ times white death rate.
Tuberculosis
Negro death rate 3½ times white death rate.
Source: Myrdal, An American Dilemma (Figures for 1929-31)
SOUTHERN PATRIOT CHART

3) There is a serious shortage of hospital beds of all types for the Negro population. In 15 states requiring segregation, only Maryland and Missouri, both strickly speaking outside the South, provide as many as 2 beds per thousand Negro population—and that is less than half the accepted standard. Many states provide less than 1/3 the standard, and in widespread areas, less than 1/10 the necessary beds are available. That means people are dying—because hospital beds say "for white only".

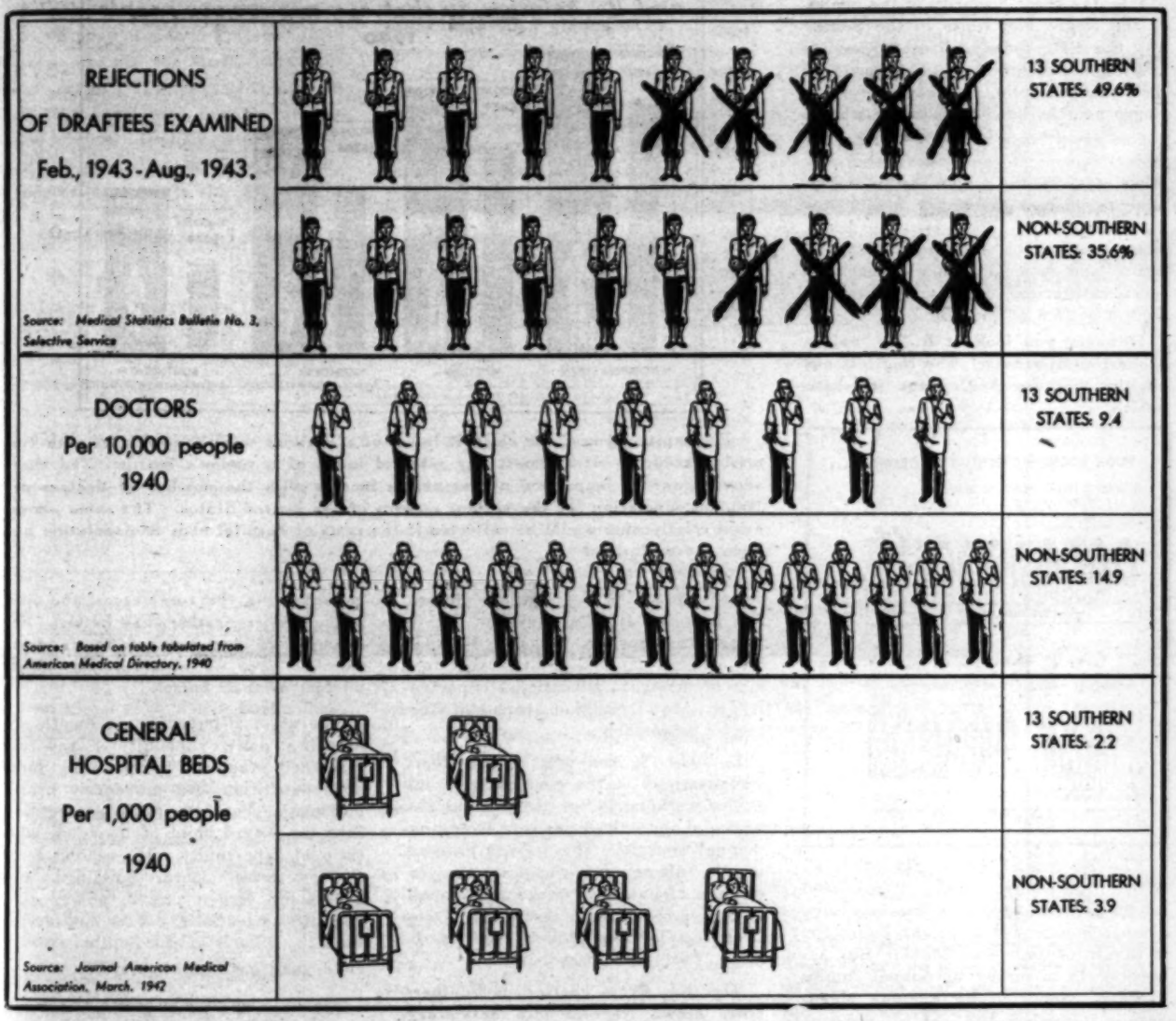
In the South, 10,000 to 11,000 Negroes die of tuberculosis yearly; yet there are less than 6,000 beds for their care. The American Public Health Association says that at least two beds for every death from TB are necessary to care adequately for this disease. That means 20 to 25,000 are needed. The situation is similar in regard to facilities for convalescent care and the mentally ill.

Even where hospital facilities for Negroes ARE available, they are usually of inferior quality. A private room, for example, is virtually unobtainable. Furthermore, in many hospitals where a Negro is admitted as a patient, the doctor of his choice: if he is a Negro; is not allowed to treat him. In Mississippi, for example, in 1940 there were no modern hospitals where a Negro physician could take his patients, and as far as we know, that is the case today. A corresponding situation prevails in many of the other Southern states. Even in cities like Atlanta and Richmond where medical colleges have control over large public wards of local hospitals, Negro physicians are not permitted to participate in their programs.

4) There is a critical shortage of Negro doctors, dentists, nurses, medical social workers and laboratory technicians—which contributes heavily to the high rate of Negro mortality. This results largely from the policy of virtually every medical school in the United States which bar Negroes from admission.



THE WHOLE SOUTH SUFFERS


REJECTIONS OF DRAFTEES EXAMINED Feb., 1943-Aug., 1943.
Source: Medical Statistics Bulletin No. 3, Selective Service
13 SOUTHERN STATES: 49.6%
NON-SOUTHERN STATES: 35.6%
DOCTORS Per 10,000 people 1940
Source: Based on table tabulated from American Medical Directory, 1940
13 SOUTHERN STATES: 9.4
NON-SOUTHERN STATES: 14.9
GENERAL HOSPITAL BEDS Per 1,000 people 1940
Source: Journal American Medical Association, March, 1942
13 SOUTHERN STATES: 2.2
NON-SOUTHERN STATES: 3.9

That the sad and shocking state of health in the South is not limited to its Negro citizens is made clear by the chart above.

In seven southern states—Virginia, North Carolina, South Carolina, Georgia, Florida, Arkansas and Louisiana—more than half of their young people—in the prime of life—were unable to meet the minimum physical and mental requirements for military service. In every Southern state at least 40 per cent of the men examined for the draft were rejected.

But those who knew the health conditions in the South need not have been surprised at those results. For every other measurement of death rates and medical facilities show the same unhealthy condition, when North and South are compared.

The infant mortality rate, for example, shows 48.6 deaths per 1000 births in the South; and 40.6 deaths in the rest of the U.S. This higher rate in the South is not due exclusively to the soaring death rate among Negro babies. The death rate among white babies in many southern states exceeds that for Negro babies in many Northern states.

Some figures just compiled by an official state body in South Carolina indicate the tremendous problem facing the whole South, Negro and white alike. The report showed that:

—Only 29 per cent of the hospitals in South Carolina were approved by the American College of Surgeons in 1946.

—Twice as many beds are needed in the state's 6 tuberculosis hospitals.

—Dental service is altogether lacking for indigent and near indigent groups. South Carolina needs 2½ times as many dentists as it has at present.

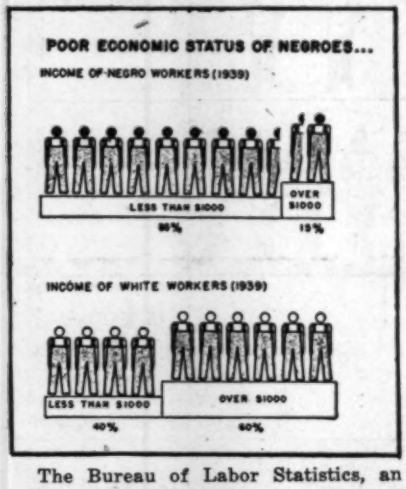
—Only 33 per cent of the state's hospital beds are available to Negroes, although they constitute 43 per cent of the state's population and their need is more acute.

DIAGNOSIS

Why the great disparity in the health of the Negro and white in the South, why the differences in life expectancy, how explain the greater killing power of the influenza germ, for example, in the Negro neighborhood than in the white?

One expert says its the 3 E's: Economics, Environment and Education. Another says, "Three major factors determine to a great extent the health status of any group: socio-economic level, educational level and availibility of health and medical care. In each of these categories, Negroes are literally 'at the bottom of the pile'."

However you look at it, it's mainly a question of money. The Negro is not healthy because he cannot purchase health.



The Bureau of Labor Statistics, an official government agency, estimated at the end of 1947 that the necessary annual income for a decent living for a family of four was $3500. But according to a survey of annual family incomes conducted by **Fortune** Magazine in December, 1947, only 4 per cent of the Negro families in the nation had an income of $3500 or higher. 21 per cent had an income from $1000 to $3000 and **75 per cent had an income below $1000.** Figures for white families were: 27 per cent over $3500, 51 per cent $1000 to $3500, 22 per cent below $1000.

The 96 per cent of America's Negro families with sub-standard income are not able to afford healthful diets, or housing conducive to healthful living, and can't afford to call the doctor when they get sick. For example, 70 per cent of Negro homes in the South in 1940 were WITHOUT RUNNING WATER or electricity.

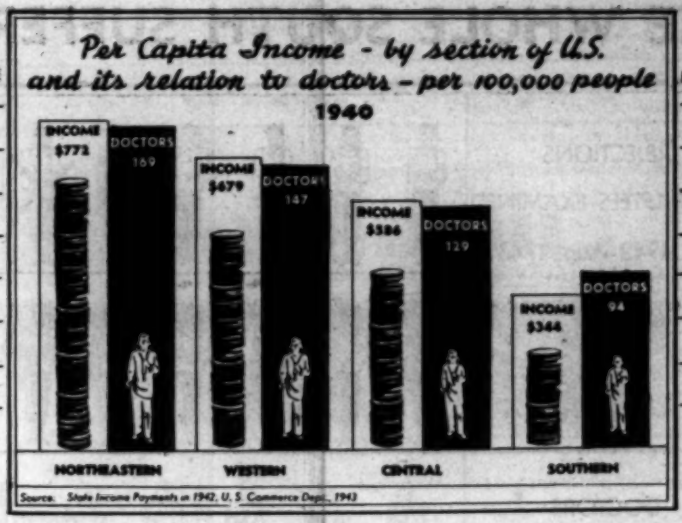
This ecomonic picture can't be separated from the segregation picture. For it is the Jim Crow system that is largely responsible for the Negroe's low income. It is Jim Crow that robs him of adequate educational opportunity; it is Jim Crow that keeps him from higher paying jobs.

In 1940, 70 per cent of the Negro wage earners in the country were unskilled workers, 24 per cent were skilled workers, and only 6 per cent were nonmanual workers. The defense program was in full swing at the time; the percentage of unskilled workers is probably higher today, as a result of the Jim Crow employment policy, last to be hired, first to be fired.

The Jim Crow ghettos in Southern cities crowd Negroes into unsanitary, disease-breeding slums discriminated against even in such matters as garbage collection. In the rural areas, the situation is worse, rather than better. For example 26 per cent of Negro farm families have no water supply within 50 feet of their homes.

Education is important to health—in breaking down superstition, and old fashioned practices, in spreading facts about nutrition and preventive health measures. Yet here again segregation robs the Negro child of an equal educational opportunity. His schools have shorter terms, poorer buildings, and equipment, larger classes, poorly paid and trained teachers, poorer bus service than the schools of the Southern white child, inadequate as they are.

Finally, disparity in health and medical care available helps explain the disparity in disease.



Per capita income, the clearest index of a region's wealth, correlates with surprising accuracy with almost any selected index of a region's health. The chart above shows a comparison of per capita income with the number of doctors per 100,000 population for the various regions of the United States. The same almost exact relationship would be reflected if the ratio of hospital beds to population had been chosen instead.

PERCENTAGE DISTRIBUTION BY INCOME OF GENERAL POPULATION AND SYPHILIS POPULATION IN WASHINGTON, D. C., 1939

	WHITE		NEGRO	
Annual Income	General Population	Syphilis Population	General Population	Syphilis Population
Under $1000	18.6	43.0	77.7	86.6
$1000-$2999	65.7	45.0	21.6	13.0
Over $3000	15.7	12.0	.7	.4
	100.0	100.0	100.0	100.0

Sourse: Syphillis in the Negro. H. H. Hazen, U. S. Public Health Supplement No. 15 to Venereal Disease Information, p. VIII.

DOCTOR'S DILEMMA

The story is told of the young lad who, desiring a copy of Edwin Embree's book **Thirteen Against the Gods**, asked the bookseller for "Thirteen Odds Against You." He might have been an absent-minded Negro medical student, for though Negro doctors are critically needed, he faces difficulty after difficulty in pursuing his training and career. We might list 13 at random:

1) The overwhelming majority of Negro youth do not receive the type of elementary and secondary education that would fit them for a college career of any sort. Furthermore, their families are so in need of economic assistance, that most Negro youth must interrupt even their early education to go to work and supplement the family income.

2) College preparatory work for medical school must be on a high level, and the Negro student, barred from state universities in the South, must often go to inferior, poorer colleges, which do not prepare him adequately for medical college. This is particularly handicapping, because there is very keen competition for medical school entrance, and the student who might be able to do the work is barred because of the standing of the college where he did his pre-med work. Yet in all likelihood, he was unable to gain admittance in the first instance to a better college, because of his color.

Discrimination in Medical Schools

3) Of the 77 medical schools in the nation, only 2 freely admit Negro applicants, and those two are Negro institutions: Howard University Medical School in Washington, and Meharry Medical School in Nashville, Tennessee. Only 85 Negro students are now enrolled in 20 other Northern and Western schools, whose enrollment includes 25,000 white students.

The deans of these schools deny discrimination for the record, but privately admit it. It is a difficult charge to prove conclusively, however, since somehow the schools destroy their records of applications. An investigation conducted by the N. Y. City Council revealed that between 1920 and 1945 only 50 Negroes graduated from the city's medical colleges, and there were during the period never more than 3 in any one school. There were no Negro medical students at Cornell, for example, from 1920 to 1942.

But the records at Howard showed 1341 applications for admission last year, with places for only 74; and at Meharry, 800 candidates applied, and there was room for only 65. Authorities at Howard stated that over 200 of the applicants last year were fully qualified —but most of these 125 students were probably not able to enter any medical school in spite of the critical need for Negro doctors.

4. Because of their families' economic status, and the high cost of a medical education, a large percentage of the Negro medical students must take outside jobs to stay in school. This is a tremendous handicap, in view of the heavy academic load in medical school, and the long hours that must be spent in hospital duty.

Discrimination in Hospitals

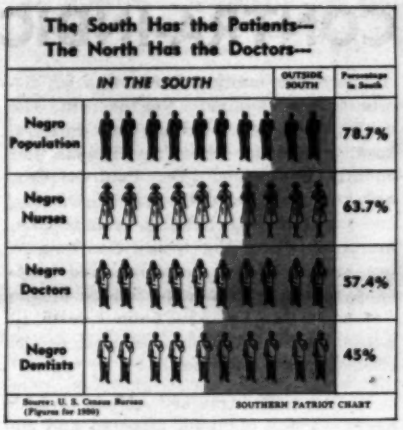
5) Yet in spite of these difficulties, about 140 graduate each year. Their big problem then is to find a hospital in which to intern. There are only 14 Negro hospitals approved for internship, just barely enough—and offering no choice to the student.

6) In order to specialize in any field in medicine, a young doctor after he completes his internship of one year in a hospital, must spend another year or two as a resident in a hospital. Yet residences are terribly difficult for the Negro doctor to find, almost impossible. Thus he is usually forced to become and stay a general practitioner, however great his talents may be in a particular field, such as surgery.

7) Upon starting his practice, the young doctor will find that in most of the South, there are no modern hospitals whose facilities he may use, and in which he may treat his patients. In the whole state of Mississippi there is none, and that is true of other Southern states as well. It goes without saying that when hospital staff appointments are made, he is not considered.

8) That he cannot treat his patients when they must be hospitalized, brings on a bread and butter problem: he often loses his patient to a white doctor, who can use hospital facilities.

9) A very serious problem for the doctor is that his patients generally have a low income level, particularly in the South—and where the need is greatest, he is unable to practice, because he cannot make a living.



A.M.A. Color Line

10) The Negro doctor is barred in the South and in the District of Columbia from membership in the American Medical Association, or more exactly, from the county and state medical associations which are affiliates of the A.M.A.

11) The Negro doctor because of the A.M.A. bar and the hospital problem has special difficulties trying to keep up to date on developments in medicine. For example, some years ago the Atlanta Medical Society was requested to admit Negro doctors just to hear the discussions of current medical problems, and refused.

12) Public health service clinics and facilities and public health service jobs are not often open to Negro doctors. It

13) Finally, the Negro doctor in the South must find it particularly difficult to endure the Southern segregation pattern. The disregard for his professional status, the day to day problems of life for the Southern Negro—housing his family in slum conditions, sending his children to inferior schools, being subjected to constant indignities—drives most good doctors North, and leaves the areas most in need without adequate medical care.

These same problems are faced by the Negro dentist, and the Negro nurse. Less than 3 per cent of the registered nurses in the U. S. are Negroes. Of the 1300 nursing schools in the country, well over 1200 are "for white only". The Negro nurse cannot count heavily on private practice, and the public health system offers few opportunities because of discrimination.

CONTRA-INDICATED

There are many other forms of discrimination against Negroes in the health field, less obvious than hospital bars or medical school restrictions, but equally important. Dr. Paul B. Cornely, on leave from Howard University, has spent a year helping various communities in the North and South work out some of these problems, and a recent report of his experiences in the **American Journal of Public Health** illuminates the situation. In most of the cities he visited he found:

1) No well organized official health agency which planned, directed and coordinated the health activities of the community. Thus, each city suffered from the lack of elemental services—always with the deficiency of services more acute for the Negro than the white population. This was especially true in regard to venereal disease clinics, hospital beds for tuberculosis, health education programs, and dental care facilities.

2) Facilities were apportioned by population percentage instead of need. This is a particularly harmful result of segregation. It seems elemental that health services must be furnished in relation to the needs of any group, rather than on a basis of its ratio in the population.

3) No Negroes on policy forming boards, which determined matters affecting the entre Negro population.

4) In voluntary health agencies, there were usually special Negro divisions to handle programs affecting Negroes, instead of an integrated approach to the problems of the whole community. This often results in the "second-hand approach"—the feeling that Negroes can get along with less than whites, and can use to advantage what has been found inadequate for the white community.

5) In these agencies, the opportunity for employment for Negro professional personnel was meager, and where Negroes were employed, there was often wage discrimination and no opportunities for advancement.

6) Finally, in the clinics, Negro patients were treated with condescension, lack of sympathy, and without respect and dignity.

It seems plain that no honest person can advocate two standards for health, one white and one black. Yet whenever separate segregated facilities are set up, that is the inevitable result.

"Separate and Equal"

IN THE 17 STATES AND D. C. WHERE SEGREGATION IS MAINTAINED BY LAW

			No. State Supported Colleges
DOCTORS	White	1 to every 843 of the white population	15 States
	Negro	1 to every 4,409 of the Negro population	None
DENTISTS	White	1 to every 2,795	4 States
	Negro	1 to every 12,101	None
PHARMACISTS	White	1 to every 1,714	14 States
	Negro	1 to every 22,815	None

Source: Journal of Negro Education, Census Reports — SOUTHERN PATRIOT CHART

Too many civic minded groups, feeling the need for Negro hospital facilities, for example, put their energies and money into an effort to establish a new hospital for Negroes only. A campaign is launched, the money is raised with difficulty, a new hospital is built—but virtually never with the equipment and facilities equal to the already existing public, tax-supported institution for whites only. The net result is to extend and perpetuate the Jim Crow system which leads to further inequalities. The same money and energy put into enlarging and extending the public hospital and making it really public would produce far greater and more beneficial results for all concerned.

A similar issue has been raised with respect to the problem of medical schools for Negroes in the South. Under pressure from the United States Supreme Court, which has insisted upon equal educational facilities for Negroes, the Southern governors are much concerned. For there are no state medical schools open to Negroes in the Southern states, it is too expensive to open 17 separate schools and the Governors are not willing to open the doors of the state university medical schools to Negro students. In their effort to escape demands of the Constitution, the Governors propose a regional school, and are negotiating with Meharry Medical School, proposing that the Southern States purchase and operate it jointly. Meharry, unfortunately, has its own financial problems, and its trustees have offered the school to the Governors Conference.

Again, this would be a backward step perpetuating discrimination — an endorsement of educational segregation. Justice demands the opening of all professional schools NOW to all qualified students.

SOUTHERN CONFERENCE EDUCATIONAL FUND, Inc.
808 Perdido Street
New Orleans 12, La.

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PRESCRIPTION

What can we do about it all?

Obviously, a many-pronged program is necessary—

- **An all out attack on segregation, to end Jim Crow in hospitals, and professional schools, in housing and education, and in the expenditure of public funds.**
- **A national health program, which will provide medical care to all our citizens, without regard to ability to pay.**
- **A community health program to meet the specific needs of each area.**
- **An overall program to raise the living standards of the Southern people, Negro and white alike.**

Jim Crow Must Go

Americans are realizing more and more that the segregation system in the South contradicts every ideal they hold dear—their Christian beliefs, their democratic traditions, their humanitarian heritage. There has never been a more favorable time for the opponents of segregation to take the offensive. National and international political considerations have put the defenders of segregation on the spot. It can be wiped out now—it must be. Think of the thousands of people that are dying without need, and put your energies into this battle for decency and justice. Realize once and for all that injustice and inequality and discrmiination will continue until segregation is ended. The time to "go slow" is past.

Young Negroes must have the opportunity to secure training in medicine, dentistry, nursing and allied fields. Negro doctors must be allowed to treat their patients in ANY institution for the care of the sick. How can it be complacently said that we "have made wonderful progress" when thousands die needlessly?

An attack on segregation is not enough however, for thousands will continue to die needlessly because they can't afford medical care. Authoritative and conservative estimates show that the average cost of good medical care today is more than $150 per family per year. We have seen that 75 per cent of the Negro families in the South earn less than $1000 per year, which is not enough for minimum food and shelter needs. Most of the white families in the South cannot afford minimum medical expenditures either. Even if we leave out of consideration entirely the fact that many families have need of medical services costing much more than the average figure of $150 a year, it is evident that a majority of the population cannot meet the costs of proper medical attention.

Compulsory Health Insurance

Clearly, the only solution of this problem is a method of payment by which the risks may be distributed among a substantial proportion of the people, and the costs of illness over a long period of time. That is the approach of the Murray-Wagner-Dingell Bill, which extends social security benefits to include complete medical care. It is financed by an employee payroll tax—in other words a compulsory health insurance plan which would ease the impact of illness on all individuals.

The Bill has been endorsed by all the labor organizations, by a great many civic groups and by many groups in the medical field. Opinion polls show it is favored by 68 per cent of the American people. But the bill has been bottled up in committee, opposed by vested interests in the medical profession and strangled by a coalition of Democrats and Republicans.

The American Medical Association, bitter foe of this legislation, has introduced a bill to divert support from the Murray-Wagner-Dingell Bill. Their proposal does little else than preserve the existing system of paying for such services and make a new demand upon the Federal treasury for a totally inadequate lump sum to provide medical care for the indigent.

It is not just the indigent, of course, who cannot afford proper medical care. A majority of the population is unprepared to meet a medical emergency. The A.M.A. tactics parallel those of the opponents of the public school system used over a century ago, attempting to substitute "poor schools" for indigent children for a free public school system.

The anti-discrimination clause in the Bill is full of loopholes, and the National Medical Association has stated they have "no confidence in the equitable administration of a program which could be controlled by an organization with the record of the A.M.A. with respect to the Negro."

P.T.A. Plan For Preventive Medicine

Preventive medicine—another phase of the problem is attacked by a bill initiated by the National Congress of Parents and Teachers, which would put federal money for the first time into the creation and expansion of local public health centers for basic services. The PTA's object is to blanket the country with disease-control measures, maternal-child health clinics, and other preventive medicine activities. It would supply public health services for 135,000,000 Americans who today either have none at all or are serviced by substandard staffs.

This would materially assist the communities in waging a battle for health. In shaping a community health program, it should be remembered that the problems of Negro health are merely exaggerations of the picture of the community as a whole. Thus any program which meets the requirements of the community needs only to be intensified or extended to meet the problems of Negro health. However, communities should learn from the mistakes reported by Dr. Cornely on the previous page.

Jim Crow Is A Killer

Two Negro athletes were critically injured in an automobile accident while en route from Clark College to a track meet in Nashville. An ambulance took the students to a hospital in Manchester, Tenn., but they were denied even first aid because of "overcrowded" conditions. They were rushed back past the scene of the accident to a hospital at Sewanee closely identified with the Episcopal church where they were again denied admittance. Forced to continue on their way to the nearest Negro hospital at Fayetteville, a distance of some 50 miles from the accident, one of the young men died and the other remained in a critical condition.

—This item appeared in the August 1947 PATRIOT under the title "Good Samaritan and Good Sportsmanship?"

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